Book of the month

Universities in the Future

A stated aim of the UK Government is to have 50% of young people going to university by 2010. We can all agree that a good education is the grounding required by every young man or woman who aspires to make a mark in life. But do the existing universities provide what good students want, and do they offer preparation for an increasingly complex and varied pattern of work?

A great expansion of universities in the UK came about in the 1960s. Before that time only a very small proportion of young men and women went to university. Then in the 1990s we had the abolition of the binary line and the former polytechnics became universities. We now have in excess of 100 universities providing a wide variety of courses both academic and vocational. But the question is increasingly heard: what are universities for? One recent investigation showed that students reading media studies had a substantially better chance of getting a job than those in more traditional subjects. An argument has ensued between those who say that a university education is a means to getting a good job and those who regard academic study (training the mind) as an end in itself. Until the era of Margaret Thatcher the second view held sway in government and the Civil Service, many of those who achieved high office having a background in the classics.

Universities are going through troubled times. They are all under pressure to provide more and better education for an increasing number of students at a lower cost per head. There is then the vexed question of teaching and research. Should some universities concentrate entirely on teaching and leave research to the better equipped and better funded? Is there a case for encouraging certain universities to become centres of excellence in research, concentrating on the graduate rather than undergraduate school as some do in the American system? There is no doubt in my mind that the best type of university is one which combines both teaching and research and that the best tutors are characterized by an excellent overall understanding of their subject together with involvement in front-line research. For all academics life has become more difficult with the Research Assessment Exercise, and those who might formerly have abandoned research in favour of teaching dare not do so for fear of being judged unproductive. The tendency to measure everything also reaches out to the Teaching Assessment Exercise, with its periodic judgments on the quality and added value of university teaching.

This all leads one to ask whether the university of the future, with all the electronic communication methods at its disposal, will be able to uphold the values of the more traditional universities. How universities will look in 25 years is the subject of *Universities in the Future*[1]. The UK Foresight Programme, managed by the Office of Science and Technology in the Department of Trade and Industry, is about developing visions. Its brief for this publication was 'State your vision for higher education at the end of the next 25 years'. The volume, edited by Professor Michael Thorne from the Open University, contains contributions from a range of academics, businessmen and strategic and economic advisers from the UK, North America and Australia. The background to the views on higher education for the next 25 years is the long-term future of universities as currently structured and the commercially oriented developments taking place in higher education in the United States. The development of the Internet, distance learning and globalization will affect the structure of the university of the future. Face-to-face teaching will survive, but perhaps closer to where individuals live rather than in a residential university. Distance learning may be an add-on or comprise the whole course. Academic terms will probably disappear and students will start their courses when and where they wish, sometimes only taking one part of them. Failure in an examination will be an incitement to try again.

An increasing commercial input into universities will bring about many changes and by 2025 we can expect some corporations to be awarding degrees. Partnerships will flourish—for example, between publishers and universities—and there will be more collaboration with industry for research purposes. With the end of the residential university and the capability of telematic learning, the opportunity exists to create mega-universities. These will have more than 100 000 students and the resultant economies in faculty time will strengthen the likelihood of institutional survival.

For the students, access to these new universities will probably be through call centres that match people to places according to their aspirations and qualifications. Universities will, and already have begun to, move away from teaching to learning and the 'me' university will develop, putting the student first and providing a lifelong learning network. Education will be competency-based, and the experience of the Western Governors' University (as described by Max Farbman) shows how collaboration between 19 states and territories in the USA has increased access to higher education. WGU is a virtual university where students can gain access to credits and competency-based degrees through the website.

So what will the universities of 2025 look like? Will they all look the same? There are several possible options. First of all, do nothing. Universities that adopt this strategy will probably disappear. Next, development of the virtual universities (for example, a middle-Asia web university) could provide education at low cost to the student. Another

low-cost type of university would abandon all courses that could not be run at a profit or that would not register in the top one or two of the market share. These would remain campus-based but would concentrate on providing a guaranteed quality of outcome for the student. A fourth alternative might be for the best universities to set up branch campuses—for example, Harvard in Australia or Oxford in Japan. Finally, there could be the World School University, which would be specialized, perhaps starting out as a faculty, with a rich endowment to support a strong research programme. It would have a physical base but multiple outlets teaching all over the world, linked by a strong communications network.

In 2025 employment will possibly be less secure and students will be looking for higher education that allows flexible study and lifelong learning. Most of the educational information will be held electronically, and the learning media will include the Internet, interactive educational software and electronic communication between student and teacher. Print on paper, though surviving, will not be the major part of the information base. Lecturers will need to change their ways and develop teamworking to include other professionals in, for example, software development and even project management. This teamworking will provide a critical analysis of the learning materials at each stage. Quality assurance will become even more demanding than at present. Continuous assessment of the learning process will be the norm and accreditation degrees will be based on competencies. Increasingly, degrees will be self-accredited.

Where will the money come from? For students attending a web-based university, the cost should be less, especially if they are working from home. However, the resources to provide all the new media and new learning will have to come from somewhere. Partnerships with employers, such as regional development agencies or commercial companies, will become commonplace. Many universities will find themselves in partnership with large corporations that sponsor their activities. With the development of information and communication technologies the scope of the mega-universities will increase and become more international. What does this all mean for medical education? Will students learn adequately from web-based courses that offer scant face-to-face contact with teachers? Some medical schools already offer remote teaching and perhaps the Open University will become a major provider. What new techniques of teaching and learning will be required to produce the doctors of the next generation? This is indeed food for thought. With limited resources many universities have hit on the idea of becoming more specialized, particularly in disciplines where research equipment is expensive. The Institute of Molecular Medicine in Oxford has shown how bringing together experts, even if only briefly, can improve cross fertilization between related disciplines. But this trend can be taken too far and it is heartening to see new medical schools being set up in universities with no tradition in medical education. The two cultures of C P Snow still exist and we should think very hard before abandoning the mixture of arts and sciences.

The man from the eighteenth century coming to visit us today would see astonishing changes in transport, communication and medicine. But he would immediately recognize the teaching methods. How students learn today is how they learnt more or less 200 years ago. As *Universities in the Future* amply shows, the time is ripe for a step-change in our learning society.

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REFERENCE

1 Thorne M, ed. *Universities in the Future* (Office of Science and Technology Foresight Programme). London: Department of Trade and Industry, 2001 [252 pp; available free of charge from DTI (www.dti.gov.uk/publications)].

In our Own Image: Eugenics and the Genetic Modification of People

David Galton
300 pp Price £20 ISBN 0-316-85592-8
London: Little, Brown, 2001

Science needs to be defended. With the Enlightenment we saw the beginnings of the widespread use of reason to manipulate nature for the benefit of mankind. As reason gave us more freedom from the darker side of nature it also questioned the authority of the ruling elites, eventually resulting in political emancipation. The position of science and reason has changed in contemporary discourse. There is now a wide feeling that interference with nature has led to many problems. Environmentalism is one expression of this; and another is the suspicion of genetic technology, with calls for more state regulation and restriction. *In our Own Image* stands in defence of science by arguing for individual freedom.

In the subtitle of his book David Galton, who is Professor of Human Metabolism and Genetics at St Bartholomew's Hospital, declares the history of genetic science so that these issues can be dealt with in a reasoned way. 'Eugenics' is derived from the Greek for 'good birth',

and Galton makes clear that manoeuvres such as preimplantation embryo selection and gene enhancement are eugenic. He also shows how the idea as well as the word goes back at least as far as Ancient Greece. Citing Plato's *Republic* and Plutarch's historical account of the city state of Sparta he gives a fascinating account of how eugenics was originally perceived by the ruling classes as a tool to improve the population. We then move to more recent history and the birth of modern evolutionary theory with Charles Darwin. The *Origin of Species* was received into a society that understood itself through the concept of race, with its justification of the class structure at home and the imperialist project abroad. The book describes how Francis Galton (cousin of Darwin and no relation to the author) used Darwin's ideas of natural selection to develop a theory of eugenics that received broad support until it was discredited by the Nazis. Galton offers disturbing examples of how eugenic ideas have since been twisted by coercive state machinery. Clearly the worst atrocities occurred under the Nazis, under whose auspices 'euthanasia' clinics sat on children's wards to eradicate the 'pathological phenotype', with the 'Final Solution' marking the ultimate perversion of eugenics. However, 10 000 'socially inadequate' people had been sterilized in California by 1935 and compulsory sterilization of people with 'inferior qualities' was still occurring in Sweden until 1976, by which time some 60 000 young women had been sterilized. Eugenic Acts were narrowly defeated in Parliament here in 1913 and 1934.

Galton carefully considers public concerns about the new gene and reproductive technologies. For example, does the technology defy nature? As well as pointing out that pacemakers and corneal implants are likewise unnatural he shows how attitudes towards previous breakthroughs in reproductive science have softened from initial revulsion to acceptance. (He cites letters to the *BMJ* in 1945 suggesting that the newly introduced artificial insemination was wrong because it 'encourages masturbation' and 'would assuredly cause a break-up of Western civilisation'.) He goes on to suggest that if parents are prepared to go to enormous expense to improve their child's environment through private education why should they not be free to enhance the child's genetic inheritance. Parallels are drawn between such freedoms and freedom for abortion. He also discusses at length the concerns surrounding how the technology could be used by insurance companies, employers and the state to discriminate against the individual. He seems to suggest that the best way to negotiate these difficulties is to support the rights of the individual.

The question becomes not whether to allow the use of the new technologies (inevitable in a society organized around the market) but how we view the relation between the individual and society. The author cites JS Mill in *On Liberty* where he suggests that 'the only purpose for which power can be rightfully exercised over any member of a civilised community against his will is to prevent harm to others'—indeed, Galton's worries about cloning derive from potential risks to the child. However, if we believe we have a right to genetic privacy it will then be inconsistent to deny an individual the right to use safe technology in starting a family. Galton marshals convincing arguments for scientific and individual freedom in gene and reproductive technology. In my opinion society is too quick to assume that our genes define who we are. It is this erroneous notion that underlies suspicion of the technology.

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The Oxford Illustrated Companion to Medicine

Editors: Stephen Lock, John M Last, George Dunea
881 pp Price £39.50 ISBN 0-19-262950-6
Oxford: Oxford University Press, 2001

First published in 1986 with a second edition in 1994, this third edition has been completely rewritten under the editorship of Stephen Lock in England, John Last in Canada and George Dunea in the United States. With the help of some 250 contributors, all acknowledged experts, they have done a truly magnificent task to encompass so much in 881 double-column pages.

To give some idea of the scope of the book here is a list of the topics included under the letter A: Abortion, Absinthe, Abuse of old people, Academic medicine, Académie de Médecine, Academies, Acupuncture, Addiction, Adverse drug reactions, Advertising, Africa (history, present and future), Age and aging, Alchemy, AIDS, Alcohol, Allergy, Allied medical professions, Alternative medicine, Altitude sickness, Anatomy, Alzheimer's disease, Anaemia, Anaesthesia, Animals as carriers of disease, Anorexia nervosa, Antibiotics and anti-infective drugs, Anti-vivisection/animal rights movements, Apothecaries, Appliances (crutches and Zimmer frames etc), Arab medicine, Architecture, Aristotle, Art, Arthritis, Arthroscopy, Associations, Asthma, Asylums, Astrology, Atheroma, Audit, Medical systems in Australia, Doctors as authors, Autopsy and Ayurvedic medicine. Where appropriate the history is given, perhaps in some instances in too great detail, and each topic is dealt with in a length proportionate to its importance in words comprehensible to the educated non-medical reader. For example, under Abortion there are paragraphs on therapeutic abortion, abortion in Britain, methods of inducing abortion including mifepristone and prostaglandins, abortion world-wide,

illegal abortion and a graph showing the legal abortion rates in different countries.

To help you find your way around there are four indexes—a general index, a people index, a list of individual conditions and diseases, and a topic index. This is a book for you to browse through, to give to a colleague who has rendered you or a member of your family some medical service, to an offspring or grandchild now studying medicine and perhaps to a non-medical spouse in the hope that it might deflect those difficult-to-answer questions.

There are some apparent omissions because of poor indexing. Anthrax, for example, is not included among the As nor does it appear in the index. It is, however, to be found under Biological weapons. Nor could I find a clear account of the various types of fever. Some of the illustrations are of indifferent quality. For example, the picture of 'goitre in a cretin' on p. 264, taken from Sir Humphrey Rolleston's book *The Endocrine Organs in Health and Disease* published in 1911, certainly shows a goitre, but of a size unlikely to be encountered nowadays, and does not show clearly the more familiar facial appearance of cretinism which is better presented, though not all that well, in another picture on p. 239. A photograph of the mummy of Rameses V (p. 423) is purported to show lesions on the face suggestive of smallpox. A colour picture of the face of a patient with smallpox would be much more informative. Rightly or wrongly one gains the impression that the illustrations used may have been taken, for reasons of economy, from older publications of the Oxford University Press.

Not often is one moved to say 'this is a must' but it is. It would make a good late Christmas present.

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Primary Care for Older People

Steve Iliffe, Vari Drennan
272 pp Price £29.50 ISBN 0-192-62951-4 (p/b)
Oxford: Oxford University Press, 2001

During the past century the UK has experienced a major demographic shift as people have lived longer. The proportion of the population over 60 is now 20%. By 2025 the number of people over 80 will increase by almost half and the number over 90 will double. These changes will have profound implications for provision of health and social care, particularly at primary care level, the site of most healthcare. Already 40% of the National Health Service budget and 50% of the social care and social services budget is spent on the over-65s. This is the background against which Steve Iliffe and Vari Drennan, experienced in general practice and community nursing, respectively, review the subject. They take us from the establishment of the NHS in 1948, through various organizational changes, to the current state with the advent of primary care groups. Although they make clear that this is not a textbook of geriatric medicine, they touch on the important causes of morbidity, mortality and disability in this age group. Where possible the authors base the text on their personal research. For example, Iliffe highlights the 75-and-over screening programme on which he did seminal work in the 1990s. The discussions are well referenced and have an international perspective. But I do have some criticisms. More could have been said about the implications of demographic change in different ethnic groups—especially since there is a widespread, and false, assumption that elderly people from minority groups will have supportive extended families. Also, the authors could have said more about the housing needs for long-term care of the elderly. But in general I recommend this latest addition to the *Oxford General Practice Series*.

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Crucial Decisions at the Beginning of Life: Parents' Experience of Treatment Withdrawal from Infants

Hazel E McHaffie, in association with P W Fowlie, R Hume, I A Laing, D J Lloyd, A J Lyon
440 pp Price £35 ISBN 1-85775-479-4 (p/b)
Abingdon: Radcliffe Medical, 2001

Having a baby admitted to intensive care is a terrible experience for parents and if the baby dies it is devastating. Not infrequently, death on a neonatal unit follows a decision to withdraw intensive care. No parent is emotionally prepared to deal with this process and its sequelae. Medical and nursing staff, too, are often left with a feeling of inadequacy—that it could have been handled better. Hazel McHaffie has assembled data that, if used by professionals, might make such events less terrible for parents in the future.

The book presents a descriptive study undertaken in three regional neonatal referral centres in Scotland. Five consultant neonatologists were co-researchers, and 59 families participated—41 married couples, 14 unmarried but in partnership and 4 single mothers. For 18 mothers this was their first pregnancy; the remaining 41 had had between one and five previous pregnancies. There were eight multiple pregnancies—five sets of twins and three sets

of triplets or quads. Of 62 babies, 34 were born at 28 weeks' gestation or below and 10 were over 40 weeks. The neonatologists referred parents after the initial bereavement appointment. Those agreeing to take part were seen by a single interviewer (HM) 3 months and 13 months after the death of their baby, and semi-structured interviews were used to document their perceptions of different aspects of the events and communication. This is a thorough and extensive piece of work, including much original material. For clinical staff—medical and nursing—I feel the key chapters are those on 'Decision Making' (decision to withdraw care), 'Management of Dying' and 'Follow-up'. Each chapter describes what happened, what the parents' perceptions were, what elements were supportive or satisfactory, and what was unhelpful or unsatisfactory.

In decision making the key elements were that parents needed clear information given in a supportive, unhurried manner, and that they did want to be actively involved. An atmosphere of mutual respect between staff and parents was appreciated, enabling parents to feel part of a decision-making team. Delays in imparting knowledge, or withholding of information in order to 'protect' parents, were unhelpful and could lead to distrust. A named consultant was seen as the key person in conducting discussions, and neonatal nurses were vital in supporting parents throughout the process. Some parents found their general practitioner or religious minister helpful, and hospital chaplains were frequently involved. Friends and relatives were of limited help at this time, so the sympathetic support of staff within the neonatal unit was particularly important. Attention to practicalities such as availability of a private room, a telephone and food and drinks was appreciated.

Almost all parents were involved in the dying process, although inevitably for some the death was too quick or too slow for them to feel comfortable. A rapid deterioration, with death occurring shortly after withdrawal of care, was usually seen as confirmation that the decision had been right, while some parents experienced an unexpectedly long decline which was almost unbearable. Many parents commented with surprise about the degree of compassion and emotional involvement of staff, and were much comforted by the fact that nurses and even senior consultants so obviously cared about their individual baby. But things can go wrong: some parents felt unprepared for the nature of the death, others doubted the decision. A thoughtless comment or inappropriate laughter nearby could be deeply hurtful, and conflicting information must be avoided. However, with an honest and sensitive approach combining respect, dignity and privacy while maintaining support, the death of a baby can be handled well.

The importance of timely and sympathetic follow-up is emphasized, with clear messages about what is helpful or hurtful to parents who are grieving and vulnerable. Time, sensitivity and familiar understanding staff are crucial. It is noteworthy that many parents benefited from participation in the study. Although they knew the interviews were not for counselling but simply for gathering of information, they expressed relief at sharing their feelings with a sensitive listener. The book covers other important issues such as requesting necropsy, management of the funeral, and the effect of an infant's death on the rest of the family. Mother's and father's feelings and opinions were often different, and this could lead to conflict and depression. Recognition of the longer-lasting effects of neonatal death is important if parents are to recover and move forward.

When I picked up this book, I was somewhat daunted by over 400 pages on withdrawal of care. However, it is well laid out and each chapter is divided into many clearly titled sections. Real parents in a real situation are the best teachers, and I found it highly informative. Anyone who is faced with decisions on treatment withdrawal in infancy can learn from Hazel McHaffie's excellent and monumental work.

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Malignant Sadness: the Anatomy of Depression

Lewis Wolpert
216 pp Price £7.99 ISBN 0-571-20727-8 (p/b)
London: Faber & Faber, 2001

A pastime of doctors is to rate the diseases they would wish not to have. Depression invariably comes high on the list. A colleague of mine, prone to recurrent episodes, remarked on the special bitterness of being a doctor-victim; and, in *Malignant Sadness*, Professor Wolpert (a research biologist) acknowledges that the burden on physicians is particularly high. The book, originally published in 1999 and now reissued with a new introduction, is derived from his own experience of depression. Responses to his personal revelations, in newspapers and in a television series, indicated that many people still hesitate to seek treatment because of the stigma attached to this condition. Wolpert himself, before his severest breakdown, subscribed to the 'sock' school of psychiatry—pull them up.

Malignant Sadness is written for lay people and for the support organizations to which many now turn. Patients with depression will find it helpful, particularly when they are recovering, and it will be an invaluable read for their relatives. Wolpert's inclination is towards a biological cause and remedy but his discussion of psychological explanations

and psychotherapy is fair and balanced. But with his enthusiasm for evidence-based medicine he barely touches upon the group of patients that causes doctors most concern—those off the evidence-based map. Most medical conditions lend themselves to an algorithmic treatment which could be provided by almost anybody. What distinguishes a competent medical practitioner from those 'anybodies' is an ability to help that minority. Indeed for an open-minded scientist Wolpert is remarkably dismissive of the principle of taking into account the individuality of each patient when prescribing: he condemns it as a misguided stance typical of alternative medicine today. By contrast, he commends the patient groups for their work with depressed people and their families. Children become depressed. Wolpert points out deficiencies in our knowledge of causes, symptomatology and management. Probably depression is underdiagnosed in children, not least because the presentation differs from that in adults; unexplained symptoms, both physical and behavioural, may have a depressive origin.

The relationship between depression and uncharacterized polysymptomatic conditions such as chronic fatigue syndrome (CFS) is explored. Depression is part of the differential diagnosis of CFS and a complication of it; but many who suffer from CFS, and those who care for them, resist the notion that it is a primary psychiatric illness. It shares with depression an inadequate vocabulary. Victims point to the feeble descriptive name and Wolpert makes the same point concerning depression: 'we certainly could do with a better word for this illness than one with a mere common connotation of being ''down''. His title *Malignant Sadness* reflects his view that depression is a pathological and destructive maldevelopment formed from the everyday experience of sadness. The widely distributed (and sometimes perhaps beneficent) 'sadness cell' undergoes malevolent differentiation, resulting in the malignant condition of depression. One wonders what is the corresponding clinical condition for malignant anxiety and whether it is recognized as such.

Finally and most welcome Wolpert tackles international and intercultural psychiatry head on. From his discussions with clinicians and sufferers in Asia and South America he concludes that depression is as heavy a burden in these places as in the UK. Many depressed individuals in developing countries lack access to the kind of services that helped Wolpert so effectively. There is a hint in the book that, though a non-believer, he does not reject totally some Eastern beliefs such as taoism. Writing this review in Sri Lanka I am surprised to read that here 'hopelessness is positively valued as it fits with the Buddhist's view of the nature of the world'. I am not surprised that, in this war-torn country, the incidence of depression in civilians has hugely increased and that 'Sri Lanka has recently acquired one of the world's highest suicide rates—47 per 100,000 in 1991—with most victims under 30 years old'.

In this review I have not otherwise touched upon suicide—the cruelest outcome of malignant sadness and one which does not always attract sympathy. Its rising incidence, especially among young men, takes its own emotional toll. How disappointing, considering the range and effectiveness of pharmacological and physical treatments, and how regrettable it would be if this became an acceptable way out of depression; might the dead hand of euthanasia not be far behind? *Malignant Sadness* is an absorbing book which I read with great profit; enjoyable, no—but thankfully I did not feel gloomier at the end than at the beginning.

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The Royal College of Physicians and its Collections: an Illustrated History

Editors: G Davenport, I McDonald, C Moss-Gibbons
168 pp Price £38 ISBN 0-907-38383-1
London: James & James, 2001

Your reviewer found himself repeatedly turning to p. 127, which is robustly occupied by a three-quarter-length portrait of Theodore Turquet de Mayerne (1573–1655), Physician to James I and to Charles I. His hand wrote the dedication to James I in the *Pharmacopoeia Londinensis* when it was published in 1618. His pink and bearded face gazes out from the portrait with an expression of shrewdness tinged with apprehension, his right hand held in a gesture of 'take me as I am' and his left hand grasping a skull. In gold lettering across the top of the portrait are the words 'Theodorus Mayerne Eques Auratus'. He seems to epitomize the gravitas, wisdom, authority and worldly success to which most Fellows of the College aspire.

It was not an easy road down which the College travelled. Founded in 1518 when Thomas Linacre (1460?–1524) gave over the front portion of his house in Knightrider Street just south of St Paul's Cathedral to accommodate the first Fellows, the College moved premises four more times, to occupy the present site in Regent's Park in 1964. This latter building was designed by Sir Denis Lasdun, combining the architectural features of the adjacent Nash terraces and those of Le Corbusier. The interior, with its stately staircase which lends itself both to formal ceremony and to the interchange of chance encounters, is a striking feature of the building.

Over the 480 years of the College's existence the Fellows were involved in several battles with institutions

that they perceived to threaten their authority. The Apothecaries sought the right to treat patients as well as dispense for them, and when the College opened the first dispensary at the College in 1698 to provide medicines for the poor this was seen as a threat by the pharmacists. The Dispensary was so successful that others soon followed in St Martin's Lane and in Gracechurch Street.

It seems astonishing today that the numbers of Fellows at any one time in the 18th century was below 100, whereas it is now over 10 000, and that it was not until 1835 that non-Oxbridge graduates were admitted to the Fellowship. The Licentiates of the College were sufficiently outraged by the Oxbridge stipulation that they besieged the College in Warwick Lane in 1767 and fought a battle with the Fellows, each side brandishing a motley range of weapons (etching on p. 35). Another agreeable illustration shows a painting by Thomas Rowlandson and Auguste Pugin (1808) of the examination of a candidate for Fellowship in the College premises in Trafalgar Square, at a time when the College was going through a period of placid self-satisfaction (p. 51).

The College possesses many treasures of interest and beauty, among which are: a silver caduceus (not a rod of iron), the President's symbol of office; a silver-gilt mace; and a gold-headed cane. The cane was originally owned by Dr John Radcliffe (1652–1714) and was passed successively to five eminent Fellows before the widow of Dr Matthew Baillie presented it to the College in 1825. The cane was carried as an emblem of the status of a physician and possessed a solid handle, in distinction to the more customary canes carried by physicians which had perforated handles in which could be held aromatic herbs or Marseilles vinegar 'of sovereign remedy against all pestilences'.

By the year 1660 the College library possessed 1278 titles as listed by Dr Christopher Merrett, the first Harveian Librarian. Unfortunately the Great Fire of London in 1666 destroyed most of these books, some 100 being rescued by Dr Merrett and the Beadle. This calamity led to a bizarre dispute between Dr Merrett, who maintained he had done all that he reasonably could to discharge his duties as custodian, and the College, who maintained that to lose most of the library came under the heading of 'serious reasons' for dismissal. The aggrieved Dr Merrett thereupon refused to give up those books which he had saved and the College riposted by sacking him. Since that time many generous donations of books have been made, in particular that of the First Marquis of Dorchester, who bequeathed his whole library to replace the disastrous losses from the Great Fire.

Geoffrey Davenport, who was Librarian to the College from 1970 until 1999, and his two co-authors are to be congratulated on producing such a splendid work, the product of intimate contact within the College supplemented by wide learning.

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